State of California Department of Consumer Affairs

BOARD OF OPTOMETRY
2420 DEL PASO ROAD, SUITE 255
SACRAMENTO, CALIFORNIA 95834
(916) 575-7170

Probation Report

Monitoring Date: _____/_____/_____

RESPONDENT: (B&P 3070/3077, CCR 1505)

Name: _____ O.D. License No.: _____

Address: _____

City: _____ Zip Code: _____

Telephone: (____) _____ Fax Number: _____

OFFICE HOURS: (B&P 3070 & 3077, CCR 1505 & 1517)

Monday	_____ - _____	Thursday	_____ - _____
Tuesday	_____ - _____	Friday	_____ - _____
Wednesday	_____ - _____	Saturday	_____ - _____
		Sunday	_____ - _____

Number of Hours Respondent present at this location: _____

OTHER LICENSED PROFESSIONALS: (B&P 3070, 3077 & 3103, CCR 1505 & 1517)

Last Name	First Name	Degree	License Number

Name of Respondent displayed in a conspicuous place? ❑ Yes ❑ No

POSTINGS (B&P 3075, 3077 & 3125, CCR 1506, 1513, 1514 & 1550)

Certificates of Registration posted in conspicuous public view?

Optometrist Certificate of Registration? (OPT)		❑ Yes	❑ No
Statement of Licensure? (SOL)	❑ Not Applicable	❑ Yes	❑ No
Branch Office Permit? (BOL)	❑ Not Applicable	❑ Yes	❑ No
Fictitious Name Permit (FNP)?	❑ Not Applicable	❑ Yes	❑ No
Corporate Registration?	❑ Not Applicable	❑ Yes	❑ No

POSTINGS (CONTINUED)

Notice to Release Contact Lens Prescriptions: (B&P 3025, CCR 1566) ❑ Yes ❑ No

Current Certification of Cardiopulmonary Resuscitation (CPR)? ❑ Yes ❑ No

(B&P 3059, CCR 1536) Expiration Date _____

Prescriptions - minimum information required: (B&P 3025, 3025.5 & 3041, CCR 1565)

- Provider Name ❑ Yes ❑ No
- Provider License Number ❑ Yes ❑ No
- Provider Address ❑ Yes ❑ No
- Provider Telephone Number ❑ Yes ❑ No
- Provider Signature ❑ Yes ❑ No
- Issue Date and Expiration Date ❑ Yes ❑ No

FACILITY (CCR 1510)

Equipment:

- Retinoscope ❑ Yes ❑ No
- Keratometer / ophthalmometer or equivalent ❑ Yes ❑ No
- Ophthalmoscope ❑ Yes ❑ No
- Tonometer ❑ Yes ❑ No
- Biomicroscope ❑ Yes ❑ No
- Phoroptor ❑ Yes ❑ No
- Tangent screen or perimeter ❑ Yes ❑ No

INFECTION CONTROL (B&P 3025.5, CCR 1520)

Disinfection Technique:

- 70% Isopropyl alcohol ❑ Yes ❑ No
- 2.5% Gluteraldehyde (Cidex® or Cavicide®) ❑ Yes ❑ No
- 3% Hydrogen peroxide ❑ Yes ❑ No
- 1:10 Dilution of sodium hypochlorite (household bleach) ❑ Yes ❑ No

Personal protection:

- Accessible hand washing facility present? ❑ Yes ❑No
- Latex gloves present? ❑ Yes ❑ No
- Respondent and Staff wash hands between patients? ❑ Yes ❑ No

CHART REVIEW

PATIENT SSN																				
Patient Age																				
MEDICAL HISTORY FORM																				
Collected																				
EXAMINATION RECORD																				
Case History																				
Chief Complaint																				
Ocular Health History																				
General Health History																				
Objective																				
Entering VA																				
Manifest Refraction																				
Best Corrected VA																				
Ocular Motility																				
Binocular Test																				
Pupil Reactions																				
Ophthalmoscopy																				
Slit Lamp Biomicroscopy																				
Tonometry																				
Visual Fields																				
Assessment																				
Diagnosis																				
Plan																				
Treatment																				
Chart Notes																				
Legible																				
Examiner Identification																				
Continuity of Care																				
Specialist Referral Indicated?																				
Appropriate Referral made?																				

COMMENTS: _____

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MONITOR INFORMATION

Name: _____ O.D. License No.: _____

Address: _____

City: _____ Zip Code: _____

Telephone: (____) _____ Fax Number: _____

I, _____, certify under penalty of perjury that the above information is true and correct. I further understand that any false, incomplete, incorrect or fabricated information may result in disciplinary action against me by the Board of Optometry.

_____ _____

MONITOR DATE

Begin Time: _____ End Time: _____ Total Hours this Visit: _____